DOCUMENT RESUME

ED 223 313 PS 012 733

TITLE Pay a Little Now or Pay a Lot Later: Exploring the Preventive Role of Community-Based MH/MR/SA Services.
INSTITUTION Virginia State Div. for Children, Richmond.
PUB DATE Dec 81
NOTE 11p.
PUB TYPE Viewpoints (120)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Cost Effectiveness; Drug Abuse; Mental Health; Mental Retardation; *Prevention; *Program Effectiveness; *Social Services; State Programs
IDENTIFIERS Virginia

ABSTRACT

The recent history of efforts in Virginia to implement preventive programs in the area of mental health (MH) and related fields is briefly recounted, and evidence of the effectiveness of prevention programs is briefly reported. For a number of years in Virginia policy makers and legislators have been provided a variety of recommendations regarding the intrinsic value of preventive services. However, it is clear that a shift to prevention, community treatment, and education of emotionally disturbed children requires management, organizational, and funding strategies which are quite different from those previously employed. The same must be said for the areas of mental retardation (MR) and substance abuse (SA), especially in the areas of prevention, community treatment/services, and education for children. As in the past, current funding cuts are likely to have a heavy impact on prevention efforts and on children's programs, even though longitudinal studies and program evaluations have shown the benefits and cost effectiveness of such preventive approaches. In view of the present austerity and the high costs of long-term remedial care, cost-effective preventive programs are highly recommended. (RH)

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PAY A LITTLE NOW OR PAY A LOT LATER: EXPLORING THE PREVENTIVE ROLE OF COMMUNITY-BASED MH/MR/SA SERVICES

An Issue Statement prepared by the Virginia Division for Children
December 1981

INTRODUCTION

In the early 1960's, President John F. Kennedy identified prevention as the most important task for professionals working in the mental health field. It appears that President Kennedy recognized the value of placing a philosophical and financial emphasis on prevention. Although decision-makers in Virginia have accepted President Kennedy's philosophical premise for some years, minimal financial support has been provided for what has been proven to be the most cost effective approach, i.e. prevention.

This paper will explore the history of such prevention efforts in Virginia, describe programs that have proven to be successful and suggest viable solutions to the remediation-prevention dilemma.

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PREVENTIVE EFFORTS IN VIRGINIA

Virginia's intellectual commitment to prevention and early intervention can be traced to 1968 when the General Assembly called for the establishment of a Commission on Mental, Indigent and Geriatric Patients. The final report of that body, This Commonwealth's Commitment, noted

> There are presently 32 mental hygiene clinics affiliated with the State system in Virginia. The Commission supports the continued funding of these clinics, with local participation, for the purpose of providing the following services:
>
> A. Early and preventive treatment focused on strengthening the family unit.
> B. Identifying, referring and giving follow-up services to patients in need of more intensive psychiatric care.

C. Providing consultative services to schools, courts and welfare departments.
D. Providing local leadership in program development, health education, consultation, agency coordination, etc.

> It is of prime importance that efforts be made for clinic services to reach families who may need this service but are not educated or conditioned to seek such service. Closer working relationships between clinics and schools, juvenile courts, welfare departments, should be established and maintained so that child and family problems can be identified and treated as early as possible.[1]

Obviously, the members of this Commission were acutely aware of the importance of early intervention, a holistic, family-centered approach to service delivery and the need for a community-level focus as opposed to institutionalization. Unfortunately their recommendations only received minimal State financial support.

In 1970, the Virginia Advisory Legislative Council stongly endorsed the 1968 recommendations in their report, Services Provided Emotionally Disturbed Children. The report states,

> Very few clinics have been able to extend their services into prevention programs despite their recognition that this is an urgently needed service in every community. While it is costly to fail to provide adequate community mental health care anywhere or to any age group, it is especially short-sighted not to provide ample and high quality health care to children both because they have a longer span of potentially productive years and because their disorders are more likely to yield to early diagnosis and treatment.
>
> Therefore, we fully support an expanded and improved network of mental hygiene clinics as a primary means of delivering some assistance to all of Virginia's emotionally disturbed children.[2]

Again, we witness both the recognition of a problem and the delineation of a viable means of addressing it; however, only the concept gained widespread support.

The Commission on Mental, Indigent and Geriatric Patients submitted another report, HOPE for Virginia's Voiceless Citizens to the 1972 Session of the Virginia General Assembly. In this document, the Commission made three key

recommendations:

> -THE COMMISSION COMMENDS THE IDEA OF MULTI-SERVICE CENTERS FOR ALL CHILDREN IN POVERTY NEIGHBORHOODS AS A MEANS OF BRINGING PREVENTIVE HELP TO CHILDREN IN DISORGANIZED FAMILIES.[3]
>
> -THE COMMISSION RECOMMENDS THAT EVERY EFFORT BE MADE BY SCHOOL SYSTEMS TO KEEP CHILDREN WITH BEHAVIOR PROBLEMS IN THE REGULAR CLASSROOM BY ASSISTANCE TO THE TEACHER.[4]
>
> -THE COMMISSION RECOMMENDS MORE FINANCIAL ASSISTANCE BY THE STATE TO LOCAL SCHOOL BOARDS FOR SPECIAL CLASSES AND REALISTIC TUITION GRANTS FOR EMOTIONALLY DISTURBED CHILDREN AND YOUTH NOT SERVED BY THE PUBLIC SCHOOLS INCLUDING THOSE OF PRESCHOOL AGE WHO NEED THERAPEUTIC PROGRAMS.[6]

In addition, the Commission noted,

> Many serious behavioral disturbances in children are related to the stress of problem families and broken homes. Often parents simply do not know how to nurture, teach and discipline their children because they lacked "parent models" in their own lives. Child development programs are in an ideal position to reach poorly functioning mothers with education in "parenting".
>
> Early childhood, we now know, is a time of tremendous learning potential. If the educational rather than the baby-sitting aspect of day-care is emphasized, there is an opportunity to develop good behavior patterns and to improve the chances of school success.[6]

The chronology continues with the Virginia Advisory Legislative Council's 1975 and 1976 reports on the Needs of Young Children. The Council offered the following observations:

> Meeting the needs of young children is of vital economic and social importance. The quality of life in the early years is often the determining factor in the ultimate physical and mental health of an individual and is his educational and vocational attainment. This fact is not presently recognized by State policy. The young child cannot always be the sole responsibility of his parents, since they often lack the knowledge to recognize his special needs and the resources to fulfill them. The State of Virginia should establish policies and implement programs which have as their goal that of providing the greatest possible opportunity for every child to develop his physical, emotional, social, and intellectual competencies to their fullest.[7]
>
> ....it is essential that children have every opportunity to develop their capacities when they are very young. It is even

> more essential that those who have a problem have it discovered early and given help. With such early help, the child can overcome a large part, if not all, of the effects of the problem. Equally important are early prevention measures designed to keep problems from developing.[8]

1976 also marked the completion of the final report of the Child Mental Health Study Group. Their report, Mental Health Services for Virginia's Children, echoed previous recommendations and placed special emphasis on the need for funding for and accountability in prevention programs. The report stated:

> In order to assure the continuous development of high quality mental health services for children, IT IS RECOMMENDED THAT FUNDING FOR MENTAL HEALTH AND MENTAL RETARDATION PROGRAMS BE AT LEAST PARTIALLY DEPENDENT ON THE INCLUSION AND SPECIFICATION OF PROGRAMS FOR CHILDREN AND YOUTH AND THAT THE CENTRAL OFFICE OF THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION DEVELOPS AND/OR ADOPTS STANDARDS FOR THE OPERATION OF THESE PROGRAMS.[9]

Six months after the Child Mental Health Study Group's report became public, the Commission on Human Resources Priorities presented their findings to then Governor, Mills E. Godwin, Jr., and the 1976 General Assembly. Under the heading, "Priorities", the Commission suggested,

> The priority, the focus of all programs in Virginia, should be Prevention. Starting now, services should be realigned so that the prevention of disabling conditions is the aim of every Human Resources agency. For example, but not limited to:
>
> Education in nutrition, "parenting", good prenatal care to assist in the prevention of the causes of birth defects.
>
> Day care for children whose mothers receive Aid to Dependent Children (ADC) payments.
>
> Home-based health care for the elderly.
>
> Transportation to needed preventative services.
>
> Close cooperation among schools, mental health centers, and juvenile centers to assist in the prevention of mental illness.[10]

Hopefully, this brief recount of legislative reports dramatizes the point that for a number of years policy-makers and legislators have been provided a variety of recommendations regarding the intrinsic value that lies in the provision of prevention services. To a certain extent, the examples that have been provided thus far are not specific by discipline, but the importance of preventing mental health problems has been acknowledged by all facets of the human service field. Consider the following:

> -In the 1977 report, Children And Youth In Trouble In Virginia prepared by the State Crime Commission, they noted "Efforts in Virginia to prevent juvenile delinquency by providing appropriate services to children and youth in trouble with their families, schools and communities have been shortsighted and initiated too late".[11]
>
> -In the 1981 report of the Virginia Department of Welfare, Reprogramming Social Services for the Eighties: A Family Focused Approach, the authors stated, "The availability of emergency and home-based services to families often allows for early intervention which prevents the later, more costly, disruption of the family unit." [12]
>
> -The VALC study, Health Education In The Public Schools (1977) noted "The alternative to the traditional crisis approach to health care and the spiraling costs of medical care is a redirection of health goals to include primary prevention through health education for every individual." [13]

The need for and importance of programs to promote good mental health and to prevent mental retardation is obviously well documented. Admittedly, Virginia has made some inroads, but there are still babies born with Fetal Alcohol Syndrome, a totally preventable condition, children are still entering foster care because supportive services were not provided to their families and the rate of youthful suicides continues to rise partially because obtaining mental health services is still a socially ostracizing practice.

Last year, the Commission on Mental Health and Mental Retardation (the Bagley Commission) requested the Secretary of Human Resources "to guide human services agencies in the development of appropriate programs for prevention

and public awareness." [14] If we are to arrest the growth in mental health problems and its ramifications, such a commitment must be made.

More recently, the Working Commiteee on the Needs of Emotionally Disturbed Children and Youth after review of past studies and current literature asserted that:

1. There currently exists no State policy with regard to prevention of emotional disturbance within the Commonwealth.
2. There are few financial incentives for Primary Prevention efforts.

   It is difficult or impossible to get reimbursement for prevention programs, and the pressure to cut non-reimbursable programs is great.[15]

In short, it is clear that a shift to prevention, community treatment and education of emotionally disturbed children requires management, organizational, and funding strategies which are quite different than what has come before. Such essentials as initial incentive money, coordination among systems, technical assistance for providers, assistance to families themselves, public education and in-service training for those caught in the shift will be necessary.

Unfortunately, the same must be said for mental retardation and substance abuse as it related to prevention and community treatment/services and education for children.

Perhaps the most disappointing and frustrating findings are found in the Division's Report to the Secretary of Human Resources on the Implementation of the Revised State Plan for the Identification and Diagnosis of Children Who Are Handicapped.

The report concluded:

"Overwhelmingly, local organizations and individuals have not actively pursued the activities outlined for them in the Revised State Plan because they were unaware of their responsibilities, felt no commitment to the process, did not consider the activities a priority, did not want to meet an increase in need for services for a non-priority

> population, or lacked services to refer children to once their handicaps were identified. The development of effective, co-operative referral mechanisms at the local level to implement the Revised State Plan has not occurred. This is reflective of inadequate leadership and assistance by state agencies. Locally, the absence of even basic information about their agency or individual responsibilities (as called for in the Revised State Plan) and the frequently identified need for basic training and technical assistance emphasizes this distressing reality. In instances where some part of a local identification and diagnosis process was in place, it was very limited and was already in existence prior to the development of the RSP".[16]

It must be remembered that Virginia's original plan was completed in 1973 and revised in 1977. In January of 1978, Cabinet members determined that full implementation of the Revised State Plan would cost additional funds. Based on the preliminary findings of a recent analysis, the Division for Children (for the period from late 1977 through 1981) was unable to identify any service delivery agency which aggressively pursued the funding they said they needed.

It seems clear that many recommendations have been made, many plans have been developed (single state agencies plans for federal funds - some inter-agency plans like the "Plan for the Development of a Statewide Program for the Prevention of Mental Illness, Mental Retardation and Substance Abuse in Virginia".) STILL, the allocation of significant time, money, and other resources to prevention, identification, diagnosis and early intervention has not followed.

In fact, with a quick analysis of the impact of current cuts, it is expected that as in the past the always underfinanced/under supported area of prevention and children's (non-institutional) programs/benefits will be hardest hit.

This comes at a time when some of the longitudinal studies in the areas have been in existence long enough to show the kind of results that consumers and direct providers knew they would.

One major study was an economic benefit-cost analysis of High/Scope Educational Research Foundation's Perry Preschool Program. Taken against the cost of program operation, the benefits amounted to a 248% return on the original investment. One major finding of interest relative to the children who attended the quality preschool was that by the end of high school, only 19 percent of the children who had attended preschool had been placed in special education classes, as against 39 percent of those who had not. This constitutes a 50 percent reduction in the need for such services. Another finding was that youth that had been children in the preschool group came before the court at a low rate of 1 in 50. In the control group the ratio was 1 in 6.[17]

These types of results are being further documented by research at such locations as the Consortium for Longitudinal Studies at Cornell.

Additionally, The Medical Evaluation of the Special Supplemental Food Program for Women, Infants and Children has been quite positive in its findings to date.[18]

Further, the work of Dr. Elsie Broussard in primary prevention for newborn infants at high risk of emotional disorders, is quite promising. The data suggests that children of parents who receive the intervention have better adjustment, that is, fewer behavior problems than those who do not receive primary intervention.[19]

Other programs and studies with similar concepts grounded in prevention and early intervention approaches are finding supportive results.

It is painfully ironic that the echo of "where is the proof that prevention works" is still ringing in our ears as we rush to submit the evidence

(that common sense knew all along) only to find that very limited funds are shrinking further.

Over the years the lack of community prevention, early identification, diagnosis and treatment of mental illness, mental retardation, and substance abuse efforts aimed at assisting Virginia's children and their families have been a re-occuring concern among many organizations across Virginia, including the Virginia General Assembly. Many feel that little progress has been made and that consistant leadership within the Department as called for in several major study recommendations has been sadly lacking.

However, fairness would dictate recognition of recent cooperative efforts of substance (no pun intended) specifically dealing with Fetal Alcohol Syndrome and women and substance issues.

It has been estimated that a mentally retarded invididual who would require a lifetime of institutionalization would cost society approximately $1.6 million during a 72 year life span. This dollar amount is based on the yearly average of $22,375 for an individual in the Virginia Mental Retardation system in 1980-81. It should be noted that the $1.6 million does not take into account inflation or other cost acceleration factors.[20] Neither does the dollar amount include the financial and human costs to the individual and his family nor the loss in human potential. Given the weight and range of these costs it would appear that an expansion of prevention efforts across program lines in austere times is even more essential.

Perhaps, Dr. Dorothy MacConkey was also mindful of the content being prepared for the 1980 Report of the President's Committee on Mental Retardation: *Prevention Strategies that Work,[21] when she concluded the summation of 1979 Virginia's Conference on Preventing Mental Retardation by stating:

"There are many pieces in the puzzle of prevention. Most of the pieces are now available. What is needed is a commitment to putting them together without delay. THE TIME IS NOW!" [22]

*Overview in Packet

-Footnotes available upon request-